CLINICAL NOTES AND CASE REPORTS

MESENTERIC CHYLOUS CYST*

REPORT OF CASE

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THE article, "Mesenteric Chylous Cysts," printed in the April 1929 edition of CALIFORNIA AND WESTERN MEDICINE, by Dr. L. A. Alesen, has prompted me to report the following case.

The etiology of chylous cyst is obscure, the occurrence of these cysts is rare, and the signs and symptoms at present are not well defined.

Considering the rarity of this condition the following case is reported:

REPORT OF CASE

History.—Mario B., white male, age five years, born of Italian parentage, first seen in consultation with Dr. Hugh Freidell on December 15, 1928. The family history was essentially negative. The parents were in good health. There was no history of miscarriages or any familial chronic diseases.

The patient was a full-term baby, normal birth, neonatal and infantile health was good. The patient had had an attack of abdominal cramps and some abdominal distention about one year ago from which he recovered without medical aid. The child gave no history of intestinal indigestion.

Physical Examination.—A well-developed and fairly well nourished child five years of age, tossing about in bed, suffering from excruciating pains located in the region of the umbilicus. The child was holding his hands on the abdomen as if suffering from severe abdominal cramps, and periodically shrieked with pain. Temperature, 100. Pulse, 98. Respiration, 20. Chest examination negative. Abdomen greatly distended, tympanitic on percussion. No abdominal spasm, slight rigidity, and well-marked tenderness over the entire abdomen. Liver and spleen were not palpable. Rectal examination negative. Extremities in no fixed position. Reflexes were normal.

Laboratory Findings.—White blood count: 25,600 with polymorphonuclear neutrophils 89 per cent; large lymphocytes, 4 per cent; small lymphocytes, 5 per cent; large mononuclears, 2 per cent. Urine, catheterized specimen: albumin trace; sugar, slight trace; acetone, heavy trace; diacetic acid, heavy trace; no pus cells or other microscopic findings.

Diagnosis.—General peritonitis, secondary to strangulation or intussusception of bowel.

An exploratory laparotomy was performed by Dr. M. Thorner.

Operation.—(By Doctor Thorner) "Anesthesia under gas ether. Right rectus incision was made. No free fluid was found, but a cyst of large size, fully a litre, presented, which proved to be a cyst of the mesentery of the lower part of the jejunum, which separated the leaves of the mesentery up to the bowel and completely flattened out the jejunum like a ribbon over its circumference. The mesentery was twisted with ecchymotic areas, with the cyst lying across and compressing the transverse colon. The entire colon was considerably congested though there was no free fluid in peritoneal cavity and no gangrene of intestines. Appendix was found not outwardly inflamed and was ablated. Cyst was excised together with intervening collapsed jejunum. Both ends of jejunum were closed and a lateral anastomosis was made. Abdominal wound closed without drainage. Hypodermoclysis of normal salt solution was administered. Patient stood the operation well. Was given hypertonic salt solution (3 per cent) and glucose per rectum.

"On December 16 was seen in the morning. Pulse good; and patient's condition was apparently good at 9:30 o'clock. Urine, only two ounces, obtained by catheterization, contained acetone and diacetic acid. One-half an hour later when seen, patient was in collapse and died at 4 p. m."

Pathological Report.—(R. D. Evans, M. D.) Gross: The specimen is a partially distended cyst containing five lobules, which are in communication with one another at a central point. Over all the cyst is 20 by 20 by 5 centimeters. The wall is gray brown, translucent, smooth, and thin. The fluid is golden yellow, and contains yellow droplets which glisten in the light. It contains approximately 1000 milliliters. Gram-stained preparations of the fluid showed no evidence of the presence of any bacteria.

The appendix vermiformis is eight centimeters long, serosa pink gray, lumen patent, and mucosa red. Coursing over the surface of the sac is a strip of small bowel ten centimeters in length in the collapsed state; and the two ends of this are tied close together in the pedicle. Bowel is five centimeters in circumference, and its lining is somewhat smooth.

Diagnosis.—Mesenteric cyst.

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* From the Children's Clinic, Santa Barbara.

* Read before the Saint Francis Hospital staff meeting.

ADENOCARCINOMA IN A FOURTEEN-YEAR-OLD BOY*

REPORT OF CASE

By ANDREW S. DAVIS, M. D.
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CANCER in youth and adolescence is rare. Students of medicine are so imbued with the idea that cancer never occurs before forty that such is accepted as a maxim. This erroneous view is directly responsible for many unsuspected lesions being first diagnosed at operation or necropsy. Adenocarcinoma does occur at relatively early ages, being the tumor of most frequent occurrence during the second decade of life, and of less prominence during the third.[1] Hennig[2] observed twelve cases among one million living children under the age of fifteen years; and subsequent to his observations, twenty-one instances have been reported in the literature occurring under fifteen years of age.

The colon is the common site of malignant growths in the digestive tract; the rectum being the site most often of true cancer. Five and a quarter per cent [3] of all carcinomas occur in the rectum. This figure places the rectum as fifth in the list of primary seats of cancer.

Transient injury is oftentimes given as a possible etiologic factor in reports on adenocarcinoma. It is very doubtful if malignant changes ever result from a single trauma, although they may follow continuous or repeated irritation to a definite structure.

A generation ago the laity believed that all tumors came from trauma, and every woman with a cancer of the breast remembered when she was pinched or kicked by a nursing infant. Everybody has been subject to many forgotten

* Read before the Alameda County Medical Society, June, 1928.